PRINTED: 09/29/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NV\$4000AGC

NAME OF PROVIDER OR SUPPLIER

LAS VENTANAS RETIREMENT COMMUNITY

SUMMARY STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Development B. WING Devel

LAS VENTANAS RETIREMENT COMMUNITY			ST CHARLEST S, NV 89135	ON	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments		Y 000		
	The findings and conclusions of any investig by the Health Division shall not be construed prohibiting any criminal or civil investigations actions or other claims for relief that may be available to any party under applicable fede state, or local laws.	d as s,			
	This Statement of Deficiencies was generated a result of an annual State Licensure survey conducted at your facility on 9/24/09. This Statement survey was conducted by the author NRS 449.150, Powers of the Health Division	r State hority			
	The facility was licensed for 60 Residential Facility for Group beds for elderly and disab persons, Category II residents. The census time of the survey was 59. Sixteen resident were reviewed and ten employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D	at the files			
	The following deficiencies were identified:				
Y 070 SS=E	449.196(1)(f) Qualifications of Caregiver-8 h training	ours	Y 070		
	NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.				
	This Regulation is not met as evidenced by Based on record review on 9/24/09, the faci failed to ensure 3 of 10 Employees received hours of annual training (Employee #1, #3 a #10).	lity I eight			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS4000AGC		B. WING		09/24/2009	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
LAS VENT	TANAS RETIREMENT CO	MMUNITY	10401 WES	T CHARLEST 5, NV 89135	ON		
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Y 070	Continued From page	2 1		Y 070			
	This was a repeat of t Licensure survey.	the 10/16/08 State					
	Severity: 2 Scope	: 2					
Y 103 SS=F	449.200(1)(d) Person	nel File - NAC 441A		Y 103			
	a separate personnel member of the staff of	e provided in subsection file must be kept for ear far facility and must incomment ates required pursuant for the employee.	ach lude:				
	Based on record revie failed to ensure 8 of 1 NAC 441A.375 regard	ot met as evidenced by: ew on 9/24/09, the facil 0 Employees complied ding tuberculosis testing 1, #4, #6, #7, #8 and #1 esidents.	ity I with g				
	Employee #1 failed to pre-employment phys	provide evidence of a sical.					
	current one step tube	provide evidence of a rculosis (TB) test, the f TB test was administe					
		provide evidence of a est, the file documented in principle of 7/30/08.	d the				
		provide evidence of a ugh a negative chest x-	ray				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		NVS4000AGC		B. WING		09/2	4/2009
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•	
LAS VENT	TANAS RETIREMENT CO	OMMUNITY		ST CHARLEST S, NV 89135	ON		
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Y 103	dated 5/15/06 was in Employee #6 failed to pre-employment physical though a negative of in the file. Employee #7 failed to current one step TB to prior two step TB test to pre-employment physical Employee #8 failed to pre-employment physical Employee #10 failed current one step TB to prior TB test was admitted. This was a repeat de State Licensure survey Severity: 2 Scope 449.200(2)(a) Person NAC 449.200 2. The personnel file residential facility mulinformation required priors and the state of the state	the file. o provide evidence of a sical and a positive TB chest x-ray dated 1/4/08 or provide evidence of a sest, the file documente the was administered in 2 or provide evidence of a sical. to provide evidence of a sical. to provide evidence of a sical. ficiency from the 10/16 sey. oe: 3 for a caregiver of a st include, in addition to pursuant to subsection up that the caregiver is perform first aid and	test, 3 was d a 008. a d the //08	Y 103	DEFICIENCY)		
	This Regulation is no	ot met as evidenced by ew on 9/24/09, the facil					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	
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	ROVIDER OR SUPPLIER	DMMUNITY		RESS, CITY, STA T CHARLEST 6, NV 89135			
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Y 106		10 Employees were trai pulmonary resuscitation l).		Y 106			
Y 255 SS=F	449.217(6)(a)(b) Peri	mits - Comply with NAC	2 446	Y 255			
	chapter 446 of NAC. (b) Obtain the necess	y with more than 10 standards prescribed in sary permits from the B Services of the Division					
	Based on observation failed to comply with	ot met as evidenced by n on 9/24/09, the facility the standards prescribe The facility failed to en	/ ed in				
	after handling dirty di supplies and before of handling clean kitche	donning clean gloves ar nware/tableware	nd				
	day are correctly date	sage and bacon from ped in the reach-in. The did dated 9/26 with use	sliced				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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Y 255	Continued From page	e 4		Y 255			
	date of 9/29). Flour a	and sugar bins are labe	led.				
	- Thermometers are a located in the side sta	available and conspicuo ation reach-ins.	ously				
		np in the freezer and an eas (dry) in the dry stor ed.					
		cream scoop storage votation - repeat violation					
	- The cutting boards of serviceable; i.e. smoot repeat violation.	on the cooks line are oth and easily cleanable	e -				
	the cooks line was in	the reach-in on the end good repair. The reach around the door frame.	h-in				
		or the soup warmers in approved for food serv					
	- The ends of the she board.	elf were not exposed pa	article				
	- Sanitizer solution fo proper concentration.	r wiping cloths was the					
	- The cutting boards of clean.	on the cooks line were					
	- Dirty dishes were no pans. Kitchenware is	ot stacked on top of cle s clean.	an				
	throughout cooking a	clean: hood interior, sho rea, fryer cabinets, doo ach-ins, and walk ins,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUR COMPLET	
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Y 255	Continued From page	e 5		Y 255			
	Ine were stored face - Hand sinks in staff riproduced warm water - Dumpster and greas lids. The ground around heavily soiled.	niners stored on the coordown on a clean surfaction and ladies rooms in within 30 seconds. See barrel were covered and the dumpster was in the kitchen we	with				
Y 450 SS=D	Severity: 2 Scope: 449.231(1) First Aid a			Y 450			
	NAC 449.231 1. Within 30 days after administrator or caregiver sidential facility is enthe facility, the adminicance cardiopulmonary advanced certificate in adult cardiopulmonary issued by the American equivalent certification accepted as proof of the This Regulation is not administration.	giver of a mployed at istrator or ined in first aid resuscitation. The n first aid and y resuscitation an Red Cross or an n will be					
	_	of met as evidenced by: ew on 9/24/09, the facil					

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(3) Persons do not smoke in those areas

(2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being

where smoking is prohibited;
(4) All electrical equipment is inspected for

- defects which may cause sparks.
- (5) All oxygen tanks kept in the facility are secured in a stand or to a wall;
- (6) The equipment used to administer oxygen is in good working condition;
- (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and
- (8) The equipment used to administer oxygen is removed from the facility when it is no longer

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his physician. The resident must be cared for pursuant to any instructions provided by the

This Regulation is not met as evidenced by: Based on record review on 9/24/09, the facility failed to ensure 2 of 10 residents received an

annual physical (Resident #3 and #5).

resident's physician.

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resident missed 6 doses from 9/17/09 through 9/22/09 because the medication was unavailable.

Resident #6 was prescribed Aricept 10 MG take one tablet by mouth every day. The resident's September 2009 MAR documented the resident missed two doses on 9/6/09 and 9/7/09 because

the medication was unavailable.

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The medication was discontinued 9/17/09.

Resident #14 was prescribed Senna Plus 8.6 mg-50 mg two tablets by mouth every night. The resident's September 2009 MAR documented the resident missed two doses of the medication on

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Y 878	,	the facility was waiting delivered.	for	Y 878			
Y 936 SS=F	resident of a resident least 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, asse information and any of the resident, including (e) Evidence of components of NRS adopted pursuant the This Regulation is not Based on record reviralled to ensure 9 of a second resident.	st be maintained for ear ial facility and retained permanently leaves th be kept locked in a plate and is protected again ne file must contain all ssments, medical other information related g without limitation: diance with the provision and the regulations	for at e e e e e d to ns of ity vith	Y 936			
	Resident #2 failed to tuberculosis (TB) test administered 7/25/08 Resident #4 failed to TB test. A one step was affected all residents.	provide evidence of a 2 t. A one step was . provide evidence of a 2 was administered 4/1/0 provide evidence of a	2 step 2 step				

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NVS4000AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

10401 WEST CHARLESTON

NAME OF PROVIDER OR SUPPLIER LAS VENTANAS RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE						
		EMENT COMMUNITY 10401 WEST CHARLESTON LAS VEGAS, NV 89135						
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Y 936	Continued From page 11		Y 936					
	Resident #6 failed to provide evidence of an two step TB test.	initial						
	Resident #7 failed to provide evidence of an two step TB test.	initial						
	Resident #8 failed to provide evidence of an two step TB test.	initial						
Resident #10 failed to provide evidence initial two step TB test.	Resident #10 failed to provide evidence of a initial two step TB test.	n						
	Resident #11 failed to provide evidence of a initial two step TB test.	n						
	Resident #15 failed to provide evidence of a current one step TB test.							
	This was a repeat deficiency from the 10/16/ State Licensure survey.	/08						
	Severity: 2 Scope: 3							